Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
HCA KINGWOOD MEDICAL CENTER
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
19

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Date Received
AUGUST 3, 2004

MFDR Tracking Number
M4-04-B734-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the *Table of Disputed Services*: "Carrier failed to properly pay claim. Per TWCC fee guidelines, the claim is to be paid as follows: medical/surgical per diem rate $1,118 x 2-days = $2,236; Implants reimbursed @ cost ($5,966.93) + 10% ($599.69) = $8,799.62 total allowable."

Amount in Dispute: $3,528.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 1, 2004: "I am filing the TWCC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for dates of service of August 4, 2003 through August 6, 2003 in the amount of $3,528.92. As a result, there was no further recommendation of payment towards the amount in dispute."

Response Submitted by: Hoffman Kelley, LLP 400 West 15th Street, Suite 1520, Austin, TX 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 4, 2003 Through August 6, 2003	Inpatient Hospital Services	$3,528.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out

the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated July 8, 2004

- 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE. RE-EVAL, MCA: PROVIDER SUBMITS IMPLANT INVOICES: $2270 PURCH PRICE FOR REV CODE 278 PATCH SOFT TISSUE RESTORE. $741 FOR REV CODE 272 BIOKNOT-LESS ANCHOR X 3 REIMBURSED 110% = $3146 ADDTL PMNT DUE TO PROVIDER. THANK YOU. SEE ATTCHED LETTER.
- C – Negotiated Contract
- F – Fee guideline MAR reduction

Re-evaluation Letter dated August 25, 2004

- *No payment exception code descriptions found on the re-evaluation letter
- The billing was reviewed according to the guidelines of the Official Medical Fee Schedule.
- Our TOTAL additional recommendation for this review is **$0.00**.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code, "C – Negotiated Contract". Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(1) states in pertinent part that "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401(c)(2)(A) states in pertinent part that "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical or surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401(c)(3)(A)(i and ii) states in pertinent part that "Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem amount (SPDA) is multiplied by the length of stay (LOS) for admission." 28 Texas Administrative Code §134.401(c)(4)(A)(i and ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%...(i) Implantables (revenue codes 275, 276, and 278) , and (ii) Orthotics and prosthetics (revenue code 274)."

3. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.

The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following item was billed under revenue code 0278 and is therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS	Total Cost from Invoice	Cost + 10%
0278	PATCH SOFT TISSUE REST	RESTORE SOFT TISSUE IMPLANT	1 at $2,270.00 EACH	$2,270.00	$2,497.00
			TOTAL ALLOWABLE	*$2,497.00*	

The division concludes that the total allowable for this admission is $2,236.00 + $2,497.00 = $4,733.00. The respondent issued payment in the amount of $5,270.70. Based upon the documentation submitted, additional reimbursement cannot be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result, no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 14, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.